



Wyoming
Community Choices
Home and Community Based Service Waivers

PARTICIPANT CHOICE OF SERVICE

Participant Name: _____
Last First Middle

Medicaid # _____

- I understand that I have been assessed by a Registered Nurse from the Public Health Office and that it has been determined that I am eligible for nursing home level of care which may be provided to me either in a nursing home or through home and community based services.
- I choose to be cared for ____ in a nursing home ____ in a community setting.
- I understand that I may be re-assessed at a later date and will be able to choose the other form of care at that time if I am found eligible.
- I will be given a choice of providers if there is more than one agency providing the Home and Community-Based Services.

I have participated in the development of my Person-Centered Plan of Care with my Case Manager and agree with the services requested. I understand that an approval of this Plan of Care is not a guarantee of eligibility or payment. Coverage of services under the approved Plan of Care is contingent upon my ongoing Medicaid eligibility.

Participant Signature

Date

Case Manager Signature

Date

Case Management Agency

Date